and variable success rates reported. This study aimed to evaluate the role of PLAD application for recurrent hip instability following THA and its long-term outcomes.
Patients and Methods: Patients undergoing PLAD were identified using hospital records coding data. Radiological and clinical data were analysed using the patient's hospital case-notes and electronic PACS system.
Results: Data was available for 15 PLAD applications with an average age of 75.1 years. The mean follow-up period was 21.9 months. PLAD prevented further dislocation in 73% of patients. Long-term follow-up of patients with PLAD remaining in-situ demonstrated that 100% of patients were independently mobile at 2-4 years and all patients were pain-free after 1-year. Sub-group analysis of risk factors identified a significantly higher ASA grade to be associated with further episodes of dislocation in patients undergoing PLAD application.
Discussion: Our results demonstrate that the majority of patients undergoing PLAD application return to independent mobility with no long-term hip pain. PLAD application should be used with caution in patients with an ASA grade of 3 or greater.

EMERGENCY ENDOVASCULAR AORTIC ANEURYSM REPAIR: CAN WE IMPROVE?

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Aims: Emergency endovascular aortic aneurysm repair(eEVAR) is proposed to decrease the high mortality rate associated with open repair (OR) and improve outcome.This study aims to assess the feasibility and effectiveness of eEVAR.An outcome comparison is made between ruptured (RA) and symptomatic aneurysms(SA).
Methods: Prospectively collected data has been analysed between July'06 and December'09, including demographics, imaging, operative details,-complications and outcomes.36 patients underwent eEVAR.CT angiography was performed for all patients and confirmed RA in 23. 34 patients received bifurcated-aortic grafts;2 had aorto-uni-iliac grafts with fem-fem crossover.
Results: 36 patients underwent successful eEVAR.Median time from diagnosis to surgery for RA was 125minutes(30-148minutes);median duration of surgery was 119minutes(95-140minutes);median blood loss was 300mls (100-500mls);median hospital stay was 5days(3-10days).13 patients(36%) developed complications including limb ischaemia 3(8.4%),chest infections 7 (19.4%),wound infection 1(2.7%),graft infection 1(2.7%),stroke 1 (2.7%),myocardial infarction 2(5%),cardiac failure 1(2.7%),impaired renal function 3(8.4%). 30 day mortality was 19.4%(7/36).This is lower than other published results for eEVAR outcomes.The mortality rate was higher in patients with RA[21.7%(5/23)] compared to SA[15%(2/13)],however,this was not statistically significant($P = 1.0$,Fishers Exact Test).
Conclusions: eEVAR is a feasible treatment option for emergency aortic aneurysm repair.It offers an effective treatment with shorter hospital stay and lower mortality compared to OR.This study supports further investigation of eEVAR in a comparative trial with OR.Our experience,however,might question the position of equipoise.

LIFE AFTER GALA

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Aims: Prior to the GALA trial there was doubt whether local anaesthetic (LA) was superior to general anaesthetic(GA) for carotid endarterectomy (CEA).The GALA trial showed no significant difference applicable to majority of patients.The aim of this study was to assess the impact of the GALA trial on clinical practice in a vascular unit.
Methods: CEAs 16-months pre-GALA trial were compared with CEAs over 8 months post-GALA.Both GA & LA were offered to all patients.Prospective data on 182 consecutive patients was analysed to evaluate change in practice and safety.
Results: 33%(43/127) of patients had LA in the pre-GALA era compared to 3.6%(2/55) in the post-GALA period($p<0.01$).During this period there was also a change with more Rapid-Access-Carotid-Endarterectomies being undertaken.In multivariate analysis the predictive factors for having LA were pre-GALA era($p<0.001$) and male sex($p<0.05$) whilst age,mode of presentation(elective/urgent) or time delay prior to surgery did not influence the type of anaesthetic.There were no statistically significant differences in complication rates between the two groups.The only death after hyperperfusion syndrome and 2 strokes both occurred in the GA group.Other complications[Haematoma(7),XIInerve palsy (5),hoarse voice(3)]were evenly distributed.There was an intra-operative fit with LA.
Conclusions: The GALA trial has changed our practice significantly without affecting results. Patients,given a choice between GA and LA for CEA,the majority choose GA.

ACHIEVING THE 62 DAY TARGET FOR THE URGENT REFERRAL OF SUSPECTED PROSTATE CANCER

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Introduction: The 62 day target, from urgent referral to treatment, has brought about significant challenges for every speciality. The aim of this audit was to assess the local urological units' performance, with regards to this target, for urgently referred patients with suspected prostate cancer.
Methods: Data was collected for urgent referrals with suspected prostate cancer between January and March 2006 and 2008, to assess the 62 day target. Between these two dates a Urology clinical nurse specialist (CNS) took an extended role in the prostate biopsy service and co-ordination of patients' journey.
Results: Between the two time periods significant improvements in all end points were noted. The average time from referral to biopsy decreased from 49 days to 20 days (T-test, $p<0.0001$), average referral to clinic time reduced from 120 days to 47 days (T-test, $p<0.0001$) and the 62 day target which was achieved in no cases in 2006 increased to 100% by 2008.
Conclusions: All patients with suspected cancer deserve to have a journey that is as streamlined and efficient as possible. With regards to prostate cancer, the local unit has redesigned their service to achieve the 62 day target.

THE LYMPH NODE YIELD OF NECK DISSECTIONS – IS THERE A DIFFERENCE BETWEEN CONSULTANT SURGEONS AND SPECIALIST REGISTRARS?

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Aims: To compare the number of lymph nodes excised in neck dissections carried out by consultant surgeons and specialist registrars at a single centre.
Methods: Retrospective analysis of 80 neck dissections over 4 years for total number of lymph nodes excised in each of the cervical oncological

levels. For each year, the last 10 neck dissections carried out by specialist registrars during their one year training at the centre were analyzed, with the last 10 neck dissections carried out by consultant surgeons. Eight registrars at different stages of training and three consultant head and neck surgeons were used. Comparison was made between the two groups for each of the six oncological levels (and sub-levels).
Results: Independent t-test analysis showed there were no statistically significant differences in lymph node yield for any oncological levels between consultant surgeons and specialist registrars ($p>0.05$). The most notable difference, albeit non-significant, was for Level III lymph nodes, with consultants yielding a mean 6.5 lymph nodes ($n = 38$) and registrars yielding 4.5 lymph nodes ($n = 24$) ($p = 0.08$).
Conclusion: The lymph node yield of neck dissections carried out by specialist registrars towards the end of their year of head and neck training does not differ significantly from consultants.

BREAST CANCER SURGERY: OUTCOMES IN THE ELDERLY POPULATION

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Aims: This study aimed to assess post-operative outcomes in elderly women undergoing breast cancer surgery in our institution.
Methods: Outcomes of all patients diagnosed with breast cancer in 2008 were reviewed. Patients were categorised according to age (= 70, 71–80 and >80 years).
Results: 284 patients were diagnosed with breast cancer in 2008. Of these, 29 did not undergo surgery (5 = 70, 4 71–80 and 17 >80): 12 declined surgical treatment and 14 had inoperable tumours. Only three patients (one 71-80 and two >80) were not offered surgery due to co-morbidities. 255 patients [176 = 70, 55 71–80 and 31 >80] underwent surgery. Median hospital stay was 1 day in each age group. 7(4.0%) patients aged = 70, 3(5.5%) aged 71–80 and 4(12.9%) aged >80 developed wound infections. Seromas occurred in 46(26.1%), 19(34.5%) and 9(29%) patients respectively. Only 1 patient (aged = 70) returned to theatre due to complications. There was no in-hospital mortality.
Conclusions: Post-operative outcomes in elderly patients undergoing breast cancer surgery are similar to those of younger patients, without an increase in length of hospital stay. This data facilitates informed and shared decision-making between patients and the multi-disciplinary team.

MANAGEMENT OF SUSPECTED APPENDICITIS IN OLDER PATIENTS: WHAT IS THE RIGHT APPROACH?

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This study compares the outcome of planned appendicectomies in patients aged 50 years or more with that in younger patients. The data on all patients from a single institution who were listed to have appendicectomies over six years were collected retrospectively. Histopathology results and operative findings for older patients (>50 years) who had negative appendicectomies were compared with that of younger patients. 1059 patients were included in the study. 125 patients were in the older group and 934 patients were in the younger group. 38 patients (30.4%) in the older group did not have appendicitis confirmed on operation, as compared to 270 patients (28.9%) in the younger group. Of those who had negative appendicectomies, 20 patients (52.6%) in the older group and 22 patients (8.15%) in the younger group were found to have significant pathologies which would have been better managed with formal midline laparotomies. The rates of negative appendicectomies were similar between both groups, the proportion of negative appendicectomies with pathologies requiring formal laparotomies were significantly greater in the older group. This justifies the need for either pre-operative radiological investigations to confirm the diagnosis or a diagnostic laparoscopy before proceeding with appendicectomy in older patients.

CLINICAL EXAMINATION AND ULTRASONOGRAPHY ARE ADEQUATE FOR THE ASSESSMENT OF GYNAECOMASTIA

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Introduction: The imaging modality used to exclude the presence of neoplasia in gynaecomastia remains controversial. We evaluated whether our practice of clinical examination in combination with ultrasonography is a reliable method for the assessment of gynaecomastia.
Methods: All patients referred with gynaecomastia to our out-patient clinic between January 2006 to December 2008 were included in the study. Pathological records during this period were examined to ensure no cases of male breast cancer were missed.
Results: A total of 53 patients were included in the study. Patients had a median age of 52 years (range 14-86 years). Median follow-up of patients was 3 months (range 0-6 months). Following clinical assessment 3 patients (5.6%) had a clinical suspicion of malignancy. Ultrasonography and subsequent biopsy confirmed malignancy in 2 patients. In the other patient ultrasonography detected benign breast pathology which resolved 6 months later. The remaining 50 patients underwent ultrasound assessment which confirmed clinical findings of benign gynaecomastia. Our study showed that clinical examination and ultrasonography have a sensitivity, specificity and negative predictive value of 100% for the exclusion of neoplasia in male gynaecomastia.
Conclusion: The use of clinical examination and ultrasonography is an effective means of the exclusion of neoplasia in gynaecomastia.

DOES THE USE OF 3D ENDOANAL ULTRASOUND IMPROVE INTEROBSERVER AGREEMENT COMPARED WITH 2D ULTRASOUND IN SPHINCTER DEFECTS?

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Background: Endoanal ultrasound (EAUS) is used in the assessment of anal sphincter defects. The aim of this study was to determine if the inter-observer agreement was better using 3D technology, which is less operator dependent, compared with 2D.
Methods: Images of ten patients undergoing EAUS were obtained in 2D and 3D. The images were interpreted by 4 specialists, 1 radiologist and 8 colorectal surgeons. Each image was graded as normal, internal sphincter injury, external sphincter injury or combined injury.
Results: The overall inter-observer agreement was low for the ten 2D and 3D images ($k = 0.16$ and $k = 0.22$ respectively). Within specialists, there was moderate agreement ($k = 0.42$ and $k = 0.44$ respectively). There was no interpretation advantage for the 3D device with the subgroup of 8 surgeons and a radiologist who do not routinely report scans ($k = 0.11$ and $k = 0.16$ respectively).